Department of Health and Mental Hygiene

Mortality and Quality Review Committee

Annual Report

Calendar Year 2010

Martin O'Malley
Governor

Anthony G. Brown
Lieutenant Governor

Joshua M. Sharfstein, MD
Secretary

Keith R. Peterson
Chair

I. THE MORTALITY AND QUALITY REVIEW COMMITTEE

The Mortality and Quality Review Committee (MQRC) examines the deaths of individuals in programs or facilities operated, licensed, or approved by the Developmental Disabilities Administration (DDA) and the Mental Hygiene Administration (MHA), within the Department of Health and Mental Hygiene.[1] The MQRC's primary goal is to identify patterns and systemic problems within the DDA and MHA provider community and make recommendations to the Secretary regarding actions to prevent avoidable injuries and avoidable deaths, and improve quality of care.

The MQRC meets no less than three times per year. Meetings of the MQRC are closed to the public and all deliberations are confidential. All records or files of the MQRC, its deliberations, findings, recommendations, and database are confidential . Members[2] may not disclose what transpired at a meeting and are not allowed to communicate directly with a provider, a State Facility Director, a family member, or guardian of the individual who is the subject of a death review. MQRC members have immunity from liability for any action as a member of the MQRC or for giving information to, participating in, or contributing to the function of the MQRC or its subcommittee. Members do not receive compensation for service on the MQRC.

The MQRC is staffed by MHA and DDA, administrations within DHMH. MHA and DDA employees who staff the MQRC are not members of the MQRC or the subcommittee of the MQRC.

II. REPORTING REQUIREMENTS

The MQRC is required to prepare a report for public distribution at least once a year. The annual report must include aggregate information that sets forth the numbers of deaths reviewed, the age of the deceased, causes and circumstances of death, a review of aggregate incident data, a summary of the MQRC's activities, and summary of findings. Summary findings should include patterns and trends, goals, problems, concerns and final recommendations, and preventative measures. Specific individuals and entities may not be identified in the report. The

1 Attachment 1: Health General Article, §5-801 – 5-810, Annotated Code of Maryland

2 Attachment 2: MQRC Membership

DDA provides the public report to all service providers licensed by DDA or operating by waiver under §7-903(b) of this article.

In addition to the annual report for public distribution, the MQRC or its subcommittee may, in its discretion, at any time, issue preliminary findings or make preliminary recommendations to the Secretary of DHMH, the Secretary of Disabilities, the Director of the DDA, the Director of the MHA, or to the Director of the OHCQ. The preliminary findings or recommendations are confidential and not discoverable or admissible.[3]

III. THE DEATH AND INCIDENT DATA REVIEW PROCESS

The Mortality and Quality Review Committee is one link in the process of the review of deaths and certain reportable incidents in the programs and facilities licensed or operated by the DDA and the MHA. The review process begins with a report of a death or a reportable incident to the OHCQ and other appropriate agencies.

The DDA has reporting requirements for deaths and incidents in their programs and facilities governed by statute or policy. The DDA issued a Policy on Reportable Incidents and Investigations which became effective July 29, 1999.[4] The purpose of the policy is to protect individuals from harm and to enhance the quality of services provided to them. The policy applies to all State Residential Centers (SRCs) and community-based agencies licensed by the DDA. [5] All deaths and certain reportable incidents in programs covered by the policy must be reported to the following entities:

- The Office of Health Care Quality (OHCQ)
- Developmental Disabilities Administration (DDA)
- Family/legal guardian/advocate(s)
- Case manager/resource coordinator
- State protection and advocacy agency (Maryland Disability Law Center)
- Local health department, and
- Police

The MHA reporting requirements for deaths occurring in an inpatient or residential treatment setting, residential crisis services, group home, residential rehabilitation program, or

[3] Md. Health – General Code Ann. §5-809; Md. Health – Occupations Code Ann. §14 –501 (2001).
[4] The *Policy on Reportable Incidents and Investigations* was revised and reissued in December 2001, April 2003, October 2003, July 2005, July 2006, August 2006, and October 2007.
[5] The reporting requirements also apply to those agencies operating by waiver under Md. Health –General Code Ann. § 7-903 (b) (2000).

psychiatric rehabilitation program is governed by Maryland Annotated Code Article Health General §10-714 (2009 Replacement Volume). If a death of an individual in any of the aforementioned programs occurs, the administration head of the program or facility must report the death:

- Immediately, to the Secretary and the sheriff, police or chief law enforcement official in the jurisdiction in which the death occurred; and
- By the close of business of the next working day to:
  - Director of the Mental Hygiene Administration;
  - Health Officer in local jurisdiction where the death occurred; and
  - State protection and advocacy agency (Maryland Disability Law Center).

Under the provisions of the statute establishing the MQRC, the OHCQ performs an investigation of each death of an individual with developmental disabilities or mental illnesses who, at the time of death, resided in, or was receiving services from programs or facilities covered under the statute. The purpose of the death investigation is to determine any deficient practice due to regulatory non-compliance. Two exceptions apply to the OHCQ death investigation: 1) OHCQ may not review the care or services provided in an individual's private home, except to the extent needed to investigate a licensed provider that offered services in the individual's home, and 2) unless a member of the Committee requests a review, the OHCQ may choose not to complete an on-site investigation of a death if the circumstances, based on review and reasonable judgment, are readily explained and require no further investigation.

Once OHCQ completes its investigation, the case is presented to the MQRC. The MQRC then reviews each death case including deficiency statements and documents pertinent to the investigation. The MQRC may request additional information and documentation including individual records, service of care records, medical records, discharge summary, autopsy reports, medication administration records, and any deficiency statements and plans of corrections if it determines further investigation is warranted. Once a request for information has been made, a provider of medical care, including dental and mental health care, a state or local government agency and a provider of residential or other services must give access to that information. The MQRC may prepare questions for the provider agency, State Facility director or other relevant person, or may request the attendance of the provider, director, or other relevant person at a MQRC meeting.

Per the current Statute, the OHCQ provides aggregate incident[6] data with investigation results to the MQRC every three months. A sub-committee of the MQRC reviews the aggregate incident data. Findings and recommendations are included in this report.

IV. MQRC ACTIVITIES AND STATISTICAL INFORMATION

In 2010, the MQRC met three times: January 25, 2010, April 19, 2010 and November 15, 2010. The MQRC reviewed a total of 466 reports of death (318 DDA cases and 148 MHA cases) for calendar year 2010. Please note that not all of the 466 cases reviewed involved a death that occurred in Calendar Year 2010. The death may have occurred in years 2005–2009 and are not included in the data analysis section in this report. Of the 318 DDA cases, 35 cases were fully investigated by OHCQ and 283 cases were recommended for No Further Action by OHCQ[7]. Of the 148 MHA cases, 4 cases were fully investigated and 144 cases were recommended for No Further Action by OHCQ. At the close of calendar year 2010, 456 of the total cases were closed and 10 cases remained open for further review (FFR). The 456 cases that were closed in 2010 included 6 FFR cases carried over from calendar year 2009. The MQRC also reviewed the aggregate incident data for Calendar Year 2009.

Part One: Mortality

Table 1 compares the number of deaths that occurred in Calendar Year 2010 among individuals receiving DDA or MHA services, to the number of deaths among all Maryland residents by age group. Data indicates that among all Maryland residents, the majority of deaths that occurred in 2010 were in the age range of 85 years and over, followed by those in the range of 75-84. By comparison, among people served by DDA and MHA, the majority of deaths in 2010 were in the age group of 55-64, followed by the age group 45-54.

6 "Aggregate Incident Data" means information or statistics maintained by the Office of Health Care Quality on the reported incidents of Level III serious injuries at health care facilities, per Health General Article § 5-801.

7 Effective April 2008, the Office of Health Care Quality implemented the Prioritization Protocol of Incidents of Death. This protocol reflects statutory requirements (Health-General/Title 5) and it augments the DDA's Policy on Reportable Incidents and Investigations and OHCQ's Incident Screening Committee Guidelines.

Number and distribution of deaths by age group

TABLE 1: NUMBER OF DEATHS OF INDIVIDUALS RECEIVING DDA OR MHA SERVICES IN 2010 COMPARED TO THE NUMBER OF DEATHS AMONG ALL MARYLANDERS BY AGE GROUP IN 2010

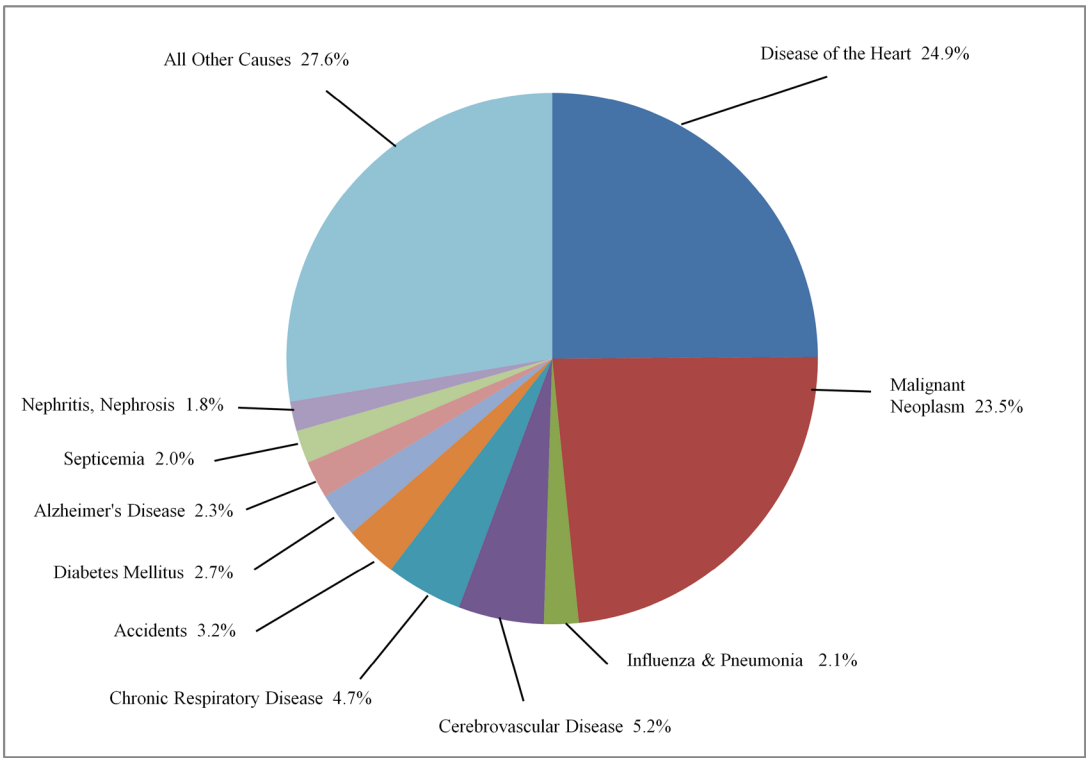
Age Group (years)	Deaths of Individuals Receiving DDA Services in 2010	Deaths of Individuals Receiving MHA Services in 2010	Deaths of All Marylanders in 2010
<1	0	0	496
1 - 4	0	0	58
5 – 14	3	1	91
15 – 24	10	3	566
25- 34	15	12	791
35 – 44	12	19	1,274
45 – 54	27	39	3,398
55 – 64	40	41	5,865
65 – 74	26	19	6,992
75 – 84	17	9	10,627
85+	1	5	12,850
Not stated	0	0	3
Male (all ages)	91	81	21,122
Female (all ages)	60	67	22,134
Total Deaths	**151**	**148**	**43,256**
Total Population	**15,107**	**122,990**	**5,773,552**

Table 2, and the pie chart graphs that accompany it, list the top ten leading causes of death that occurred in calendar year 2010 among individuals receiving DDA or MHA services and compares those causes of death to the top ten leading causes of death among all Maryland residents. While two of the top three causes of death are shared by all three categories, the prevalence of pneumonia among the DDA population, and accidents among the MHA population are worthy of attention.

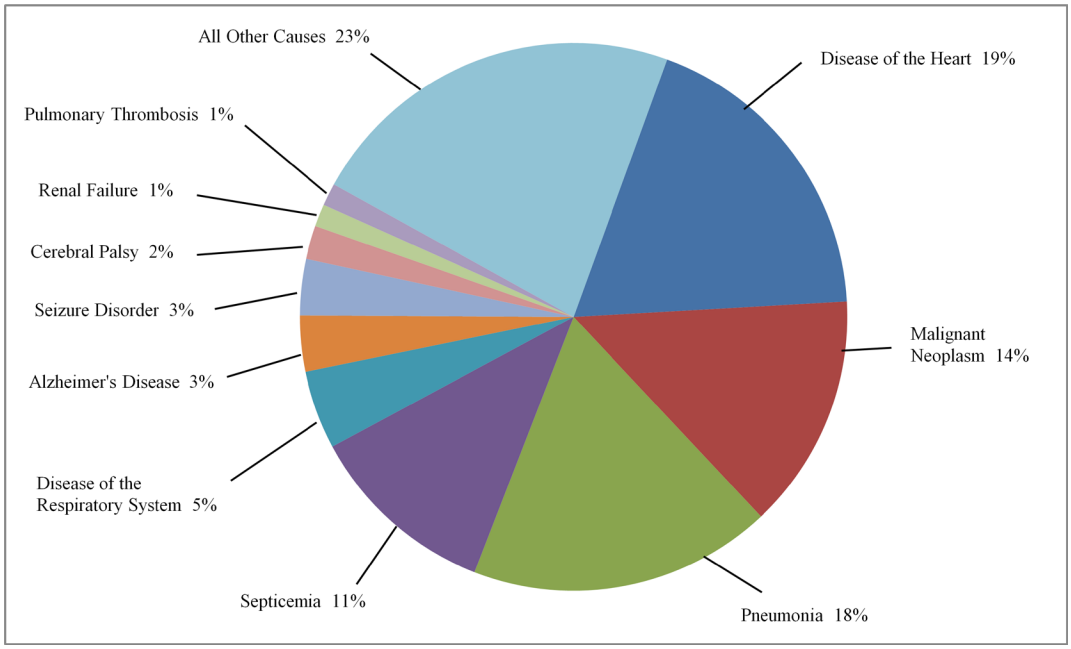
TABLE 2: TOP 10 LEADING CAUSES OF DEATHS IN 2010

Rank	Leading Causes of All Marylanders Deaths 2010	Leading Causes of the DDA Deaths 2010	Leading Causes of the MHA Deaths 2010
1	*Disease of the Heart*	*Disease of the Heart*	*Disease of the Heart*
2	*Malignant Neoplasm*	*Pneumonia*	*Accidents*
3	*Cerebrovascular Diseases*	*Malignant Neoplasm*	*Malignant Neoplasm*
4	*Chronic Lower Respiratory Disease*	*Septicemia*	*Suicide*
5	*Accidents*	*Disease of the Respiratory System*	*Renal Disease*
6	*Diabetes*	*Alzheimer's Disease*	*Influenza, Pneumonia & Septicemia*
7	*Alzheimer's Disease*	*Seizure Disorder*	*Pulmonary Embolism, Cerebrovascular Disease & Diseases of the Respiratory System*
8	*Influenza & Pneumonia*	*Cerebral Palsy*	*Unknown Causes & Cirrhosis of the Liver*
9	*Septicemia*	*Renal Failure*	*ALS, Diabetes & Chronic Lower Respiratory Disease*
10	*Nephritis, Nephrotic Syndrome & Nephrosis*	*Pulmonary Thrombosis*	*Dementia, COPD, AIDS & Parkinson's Disease*

Percent Distribution of Leading Causes of Death – All Maryland Residents 2010



Percent Distribution of Leading Causes of Death – DDA 2010



Percent Distribution of Leading Causes of Death – MHA 2010

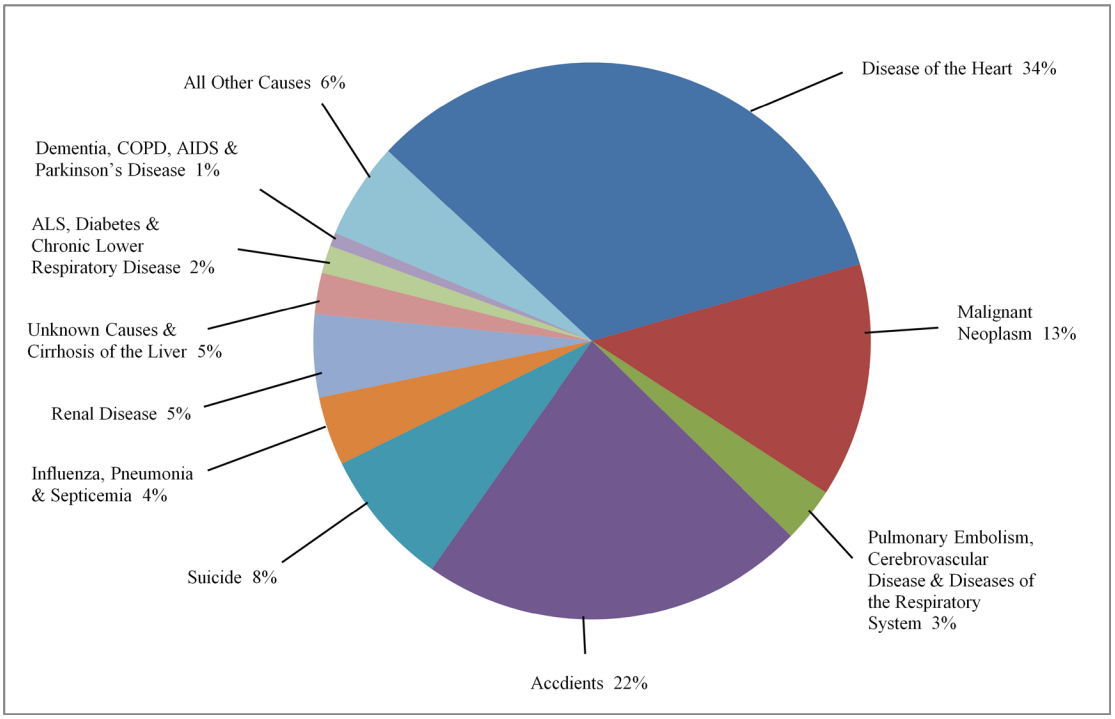


TABLE 3: NUMBER OF DEATHS OF INDIVIDUALS RECEIVING DDA OR MHA SERVICES IN 2009 COMPARED TO THE NUMBER OF DEATHS AMONG ALL MARYLANDERS BY AGE GROUP IN 2009

Age Group (years)	Deaths of Individuals Receiving DDA Services in 2009	Deaths of Individuals Receiving MHA Services in 2009	Deaths of All Marylanders in 2009
<1	0	0	541
1 - 4	0	0	67
5 – 14	1	3	100
15 – 24	12	5	574
25- 34	10	12	818
35 – 44	19	31	1,452
45 – 54	35	56	3,690
55 – 64	48	46	5,721
65 – 74	23	21	7,065
75 – 84	12	12	10,921
85+	5	4	12,812
Not stated	n/a	0	2
Male (all ages)	92	97	21,581
Female (all ages)	73	93	22,182
Total Deaths	**165**	**190**	**43,763**
Total Population	**16,468**	**116,779**	**5,699,478**

TABLE 4: NUMBER OF DEATHS OF INDIVIDUALS RECEIVING DDA OR MHA SERVICES IN 2008 COMPARED TO THE NUMBER OF DEATHS AMONG ALL MARYLANDERS BY AGE GROUP IN 2008

Age Group (years)	Deaths of Individuals Receiving DDA Services in 2008	Deaths of Individuals Receiving MHA Services in 2008	Deaths of All Marylanders in 2008
<1	0	0	617
1 - 4	0	0	88
5 – 14	2	1	108
15 – 24	15	12	641
25- 34	12	24	796
35 – 44	10	45	1,518
45 – 54	35	89	3,686
55 – 64	37	67	5,334
65 – 74	27	28	7,036
75 – 84	21	13	11,330
85+	7	3	12,690
Not stated	n/a	0	5
Male (all ages)	104	144	21,747
Female (all ages)	62	138	22,102
Total Deaths	**166**	**282**	**43,849**
Total Population	**17,237**	**103,833**	**5,633,597**

Tables 5 and 6 list the top ten primary causes of death for years 2009 and 2008 among all residents of Maryland, and those served by DDA and MHA.

TABLE 5: TOP 10 LEADING CAUSES OF THE DEATHS 2009

Rank	Leading Causes of the DDA Deaths 2009	Leading Causes of the MHA Deaths 2009	Leading Causes of death for all Maryland Residents 2009[1]
1	Disease of the Heart	Disease of the Heart	Disease of the Heart
2	Influenza[3]	Accidents[2]	Malignant Neoplasm
3	Pneumonia[3]	Malignant Neoplasm	Cerebrovascular diseases
4	Septicemia	Diseases of the Respiratory System	Chronic Lower Respiratory Diseases
5	Malignant Neoplasm[4]	Suicide	Accidents
6	Diseases of Respiratory System[4]	Septicemia	Diabetes Mellitus
7	Cerebrovascular diseases	Influenza[5]	Septicemia
8	Alzheimer's Disease[6]	Pneumonia[5]	Influenza
9	Bowel Obstruction & Perforation [6]	Renal Disease	Alzheimer's Disease
10	Nephritis, Nephrotic Syndrome, & Nephrosis[6]	Cerebrovascular Diseases	Nephritis, Nephrotic Syndrome, & Nephrosis

Notes:

1. *2009 data not yet available pending DHMH Vital Statistics Administration report.*
2. *Accidents included 2 deaths from choking.*
3. *– 6. Cause of deaths tied for per cause, per population.*

TABLE 6: TOP 10 LEADING CAUSES OF THE DEATHS 2008

Rank	Leading Causes of the DDA Deaths 2008	Leading Causes of the MHA Deaths 2008	Leading Causes of death for all Maryland Residents 2008[1]
1	Influenza[3]	Disease of the Heart	Disease of the Heart
2	Pneumonia[3]	Accidents	Malignant Neoplasm
3	Disease of the heart	Malignant Neoplasm	Cerebrovascular diseases
4	Septicemia	Diseases of the Respiratory System	Chronic Lower Respiratory Diseases
5	Malignant Neoplasm	Suicide	Diabetes Mellitus
6	Disease of Respiratory System[4]	Cerebrovascular Diseases	Accident[2]
7	Epilepsy[4]	Influenza[5]	Influenza[5]
8	Cerebrovascular Diseases	Pneumonia[5]	Pneumonia[5]
9	Alzheimer's Disease	Septicemia	Septicemia
10	Accident[2]	Liver Disease	Alzheimer's Disease

Notes:

1. *Data provided by DHMH Vital Statistics Administration.*
2. *Accidents - primarily automobile related, 4 were choking related accidents.*
3. *– 5. Cause of deaths tied per cause, per population.*

In 2008 and 2009, Influenza was the second leading cause of death for people receiving services from DDA. In 2009 and 2010, there was a greater effort on education for providers and

people receiving services to get flu vaccines. This may have contributed to the fact that influenza was not even in the top ten causes of death for people receiving services from DDA in 2010.

In 2009, the ninth leading cause of death for people receiving DDA services was Bowel Obstruction and Perforation. Training is now offered several times each year for providers and their staff. This cause of death was also not in the top ten causes of death for people receiving DDA services in 2010.

Table 7 compares cases in which the cause of death was intentional self-harm (suicide) for people served by MHA across 2008, 2009 and 2010. The table breaks down the suicides by method used.

TABLE 7: CASES WHERE INTENTIONAL SELF-HARM (SUICIDE) WAS THE CAUSE OF DEATH (MHA) 2008-20010

SUICIDE METHOD	MHA 2008	MD 2008	MHA 2009	MD 2009	MHA 2010	MD 2010
Drug Overdose (intentional self harm)					1	
Alcohol Overdose					0	
Poly Substance Intoxication					0	
Hanging	4		6		4	
Asphyxiation	1				0	
Jumping			1		2	
Discharge of Firearms	6	259	2	247	1	223
Carbon Monoxide Intoxication					0	
Self-Cutting	2		1		0	
Drowning			1		1	
Other & Unspecified		234		299	0	282
TOTAL	**13**	**493**	**11**	**546**	**9**	**505**

Part Two: Aggregate Incident Data

For providers supporting individuals with developmental disabilities, incidents are reportable according to guidelines established by DDA's Policy on Reportable Incidents and Investigations (PORI, latest revision, October 2007). Reportable incidents are reviewed within OHCQ according to guidelines formalized in the appendix 6 of PORI. From the many incidents reported, the OHCQ Triage Unit and the weekly Incident Screening Committee (ISC) must determine which incidents are to be further investigated, and the priority for investigation, with an "A" priority investigation initiated within two working days of assignment, a "B" priority

initiated within four working days, to a “C” level investigation initiated within 30 working days of assignment. Discriminations employed for investigation include the severity and type of incident reported, track record of the licensee, characteristics and number of consumers served, 21-day internal reports, etc. Additionally, it should be noted that the reporting of incidents, although mandatory, is a self-reporting process with the question that some incidents may go unreported.

Those incidents that are assigned for on-site investigation by OHCQ may yield a “substantiated” or “unsubstantiated” classification. In this context, “substantiated” means that the alleged type of incident (abuse, medication error, fracture, etc.), upon investigation, was found to have occurred. “Unsubstantiated” means that the alleged type of incident, upon investigation, did not occur. Each investigation may also result in a report of regulation deficiencies (a “Statement of Deficiencies [SOD]”). If no non-compliance issues are noted during the investigation, a closure letter, identifying that no deficient practices were noted, is sent to the provider agency. When deficiencies are cited, the provider/licensee must submit for approval a plan of correction (POC). If the agency’s POC is determined by OHCQ to be acceptable, no further action may be required. If the POC is not deemed acceptable, additional plans of correction for the cited deficiencies are required. The Appendix 6 of PORI requires that “A” priority investigations receive follow-up review from OHCQ. Incidents receiving a “B” or “C” priority classification may receive follow-up review, based on both the investigator’s or coordinator’s recommendation.

V. FINDINGS, DISCUSSION AND RECOMMENDATIONS

The MQRC reviewed 446 reports of death (318 DDA cases and 148 MHA cases) in calendar year 2010. A large majority of the cases (427 of 446 or 91.6%) were thoroughly reviewed by OHCQ and validated by the MQRC to require no further action. The remaining cases (35 for DDA and 4 for MHA) were thoroughly reviewed by OHCQ and MQRC due to the circumstances of each case. By the close of calendar year 2010, the vast majority of the cases (456 of 466 or 97.8%) had been closed.

From an assessment of the data and the supporting documentation, the following factors were noted as issues wherein specific interventions may be effective in the prevention of severe incidents:

CAUSE #1: Pneumonia continues as a leading cause of death for DDA clients.

Recommendation:

Pneumonia, which is recorded as one of the leading causes of death among DDA clients for years 2008 and 2009, remains a near primary cause of death among DDA clients again in 2010. As pneumonia can result from various causes and conditions, the MQRC recommends that these cases are tracked carefully by both providers and OHCQ so the root causes may be identified and analyzed. Continued vigilance in educating clients about flu hygiene, and administering flu and pneumonia vaccines is recommended in serving both DDA and MHA client populations.

CAUSE #2: Choking issues continue to be a concern as a cause of death as noted in prior annual reports.

Recommendation:

The protocols implemented by DDA to reduce choking deaths, which have proven effective in lowering the number of choking deaths among clients, should be referred to MHA as a potential way to reduce related accidental deaths among the MHA client population.

CAUSE #3: Septicemia continues to be a leading cause of death for MHA and DDA

Recommendation:

It is suggested that alerts to provider agency staff be made regarding the dangers of infections. Promoting early treatment of infections may be an effective strategy for combating Septicemia, especially within the DDA client population.

In conclusion, the MQRC acknowledges the lack of timeliness in the submission of the 2010 annual report, but wishes to acknowledge that the DDA and MHA have dedicated additional staff resources to serve the committee going forward to ensure that future MQRC reports will be comprehensive and timely in their submission.

Further, the MQRC wishes to commend the Governor and the State Legislature for responding to MQRC 2009 recommendations by proposing within the FY 2013 budget the addition of OHCQ surveyors to more adequately investigate and review reported cases.

ATTACHMENT 1

Maryland HEALTH-GENERAL Code Ann. § 5-801
Downloaded November 16, 2011
*** Current through all chapters of the 2011 Special Session of the General Assembly ***

TITLE 5. DEATH
SUBTITLE 8. MORTALITY AND QUALITY REVIEW COMMITTEE.

§ 5-801. Definitions [Abrogation of *amendment* effective December 31, 2012]

(a) In general. -- In this subtitle the following words have the meanings indicated.

(b) Aggregate incident data. -- "Aggregate incident data" means information or statistics maintained by the Office of Health Care Quality on the reported incidents of Level III serious injuries at health care facilities.

(c) Committee. -- "Committee" means the Mortality *and Quality* Review Committee.

HISTORY: 2000, ch. 470; 2006, ch. 268.

§ 5-802. Established; purpose [Abrogation of *amendment* effective December 31, 2012]

(a) Established. -- There is a Mortality *and Quality* Review Committee established within the Department.

(b) Purpose. -- The purpose of the Committee is to prevent avoidable injuries and avoidable deaths and to improve the quality of care provided to persons with developmental disabilities.

HISTORY: 2000, ch. 470; 2006, ch. 268.

§ 5-803. Duties [Abrogation of *amendment* effective December 31, 2012]

The Committee shall:

1) Evaluate causes or factors contributing to deaths in facilities or programs operated or licensed by the Mental Hygiene Administration and the Developmental Disabilities Administration or operating by waiver under § 7-903(b) of this article;

(2) Review aggregate incident data regarding facilities or programs that are licensed or operated by the Developmental Disabilities Administration or operating by waiver under § 7-903(b) of this article;

(3) Identify patterns and systemic problems and ensure consistency in the review process; and

(4) Make recommendations to the Secretary and the Secretary of Disabilities to prevent avoidable injuries and avoidable deaths and improve quality of care.

HISTORY: 2000, ch. 470; 2001, ch. 640; 2006, ch. 268.

§ 5-804. Composition; terms; removal; expenses; staff; chairperson; quorum; meetings

(a) Composition. -- The Committee shall consist of 18 members appointed by the Secretary, including the following:

(1) A licensed physician who is board certified in an appropriate specialty;

(2) A psychopharmacologist;

(3) A licensed physician on staff with the Department; (4) Two specialists, one in the field of developmental disabilities and one in the field of mental health;

(5) Two licensed providers of community services, one for persons with developmental disabilities and one for persons with mental illnesses;

(6) Two consumers, one with a developmental disability and one with a mental illness;

(7) Two family members, one representing a consumer with a developmental disability and one representing a consumer with a mental illness;

(8) The Deputy Secretary of Behavioral Health and Disabilities or the Deputy Secretary's designee;

(9) The Director of the Office of Health Care Quality;

(10) A licensed physician representative from the Medical Examiner's Office;

(11) A licensed nurse who works with persons with developmental disabilities in a program operated by a State licensed provider in the community;

(12) A member of an advocacy group for persons with disabilities; and

(13) Two members of advocacy groups, one for persons with developmental disabilities and one for persons with mental illnesses.

(b) Terms. --

(1) The term of each member appointed under subsection (a) (1), (2), (4), (5), (6), and (10) of this section is 3 years.

(2) A member who is appointed after a term has begun serves only for the rest of the term and until a successor is appointed.

(3) A member may not be appointed for more than two consecutive full terms.

(4) The terms of the members are as follows:

(i) One-third of the members shall be appointed for terms of 3 years commencing October 1, 2000;

(ii) One-third of the members shall be appointed for terms of 2 years commencing October 1, 2000; and

(iii) One-third of the members shall be appointed for terms of 1 year commencing October 1, 2000.

(5) At the end of a term, a member continues to serve until a successor is appointed.

(c) Removal of member. -- The Secretary may remove any member of the Committee for good cause.

(d) Reimbursement for expenses. -- A member of the Committee:

(1) May not receive compensation for service on the Committee; but

(2) Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(e) Staff. -- The Committee shall be staffed by the Department.

(f) Membership limitations. --

(1) An employee of the Developmental Disabilities Administration or the Mental Hygiene Administration may not be a member of the Committee or any subcommittee of the Committee.

(2) The Director of the Office of Health Care Quality may not serve on a subcommittee of the Committee or vote on the disposition of an individual mortality review that was previously reviewed by the Office of Health Care Quality.

(g) Chairperson. -- The Secretary shall select a chairperson from among the members of the Committee.

(h) Quorum. -- A quorum of the Committee shall be a majority of the appointed membership of the Committee.

(i) Frequency of meetings. -- The Committee shall meet not less than three times a year.

HISTORY: 2000, ch. 470; 2001, ch. 640; 2006, ch. 268; 2009, chs. 48, 49.

§ 5-805. Evaluation of deaths of certain service recipients with developmental disabilities

(a) Review of death of certain service recipients. --

(1) Except as provided in paragraph (3) of this subsection, the Office of Health Care Quality shall review each death of an individual with developmental disabilities or with a mental illness who, at the time of death, resided in or was receiving services from any program or facility licensed or operated by the Developmental Disabilities Administration or operating by waiver under § 7-903 (b) of this article, or any program approved, licensed,

or operated by the Mental Hygiene Administration under § 10-406, § 10-901, or § 10-902 of this article.

(2) The Office of Health Care Quality may not review the care or services provided in an individual's private home, except to the extent needed to investigate a licensed provider that offered services at that individual's home.

(3) Unless a member of the Committee requests a review, the Office of Health Care Quality may choose not to review a death if the circumstances, based on reasonable judgment, are readily explained and require no further investigation.

(b) Final report -- Submission. -- Within 14 days of the completion of each investigation, the Office of Health Care Quality shall submit to the Committee its final report for each death.

(c) Final report -- Review by Committee. -- The Committee shall:

(1) Review each death report provided by the Office of Health Care Quality; or

(2) Appoint a subcommittee of at least four members, one of whom shall be a licensed physician or nurse, to review death reports and report and make recommendations to the full Committee.

(d) Further investigation. --

(1) On review of the death report, if the Committee or its subcommittee determines that further investigation is warranted, the Committee or subcommittee may request additional information, including consumer records, medical records, autopsy reports, and any deficiency statements and plans of correction.

(2) The Committee or subcommittee may choose to prepare questions for the provider, State residential center director, or other relevant person or may request the attendance of the provider, director, or other relevant person at a Committee or subcommittee meeting.

(3) Except as provided in paragraph (2) of this subsection, Committee members may not communicate directly with the provider, a State residential center director, a State psychiatric superintendent, or a family member or guardian of the individual who is the subject of a death report.

HISTORY: 2000, ch. 61, § 7; ch. 470; 2001, ch. 29, § 1; ch. 640; 2006, ch. 268.

§ 5-806. Requests for information

Upon request of the chairman of the Committee or subcommittee, and as necessary to carry out the purpose of the Committee, the following shall immediately provide the Committee or subcommittee with access to information and records regarding an individual whose death is being reviewed:

(1) A provider of medical care, including dental and mental health care;

(2) A State or local government agency; and

(3) A provider of residential or other services.

HISTORY: 2000, ch. 470; 2006, ch. 268.

§ 5-806.1. Office of Health Care Quality to provide and review aggregate incident data; consultants (Abrogation of section effective December 31, 2012.)

(a) Periodic data. --

(1) The Office of Health Care Quality shall provide aggregate incident data to the Committee once every 3 months.

(2) When providing aggregate incident data to the Committee, to the extent practicable, the Office of Health Care Quality shall identify trends and patterns that may threaten the health, safety, or well-being of an individual.

(b) Review. -- The Committee shall review the aggregate incident data and make findings and recommendations to the Department on system quality assurance needs.

(c) Consultants. -- The Committee may consult with experts as needed to

carry out the provisions of this section.

HISTORY: 2006, ch. 268.

§5-807. Immunity from liability

A person shall have the immunity from liability under § 5-637 of the Courts Article for any action as a member of the Committee or for giving information to, participating in, or contributing to the function of the Committee or subcommittee.

HISTORY: 2000, ch. 470; 2006, chs. 44, 268.

§ 5-806.1. Office of Health Care Quality to provide and review aggregate incident data; consultants (Abrogation of section effective December 31, 2012.) Abrogated.

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HISTORY: 2000, ch. 470; 2006, chs. 44, 268

§ 5-808. Annual public report; preliminary findings or recommendations (Abrogation of amendment effective December 31, 2012.)

(a) Annual public report. --

(1) At least once in a calendar year, the Committee shall prepare a report for public distribution.

(2) The report shall include aggregate information that sets forth the numbers of deaths reviewed, the ages of the deceased, causes and circumstances of death, a review of aggregate incident data, a summary of the Committee's activities, and summary findings.

(3) Summary findings shall include patterns and trends, goals, problems, concerns, final recommendations, and preventative measures.

(4) Specific individuals and entities may not be identified in any public report.

(5) The Developmental Disabilities Administration shall provide the report to the facilities or programs that are operated or licensed by the Developmental Disabilities Administration or operating by waiver under § 7-903(b) of this article.

(b) Preliminary findings or recommendations. --

(1) In addition to the public report issued under subsection (a) of this section, the Committee or its subcommittee may at any time issue preliminary findings or make preliminary recommendations to the Secretary, the Secretary of Disabilities, the Director of the Developmental Disabilities Administration, the Director of the Mental Hygiene Administration, or to the Director of the Office of Health Care Quality.

(2) Preliminary findings or recommendations shall be confidential and not discoverable or admissible under § 1-401 of the Health Occupations Article.

HISTORY: 2000, ch. 470; 2002, ch. 19, § 9; 2006, ch. 268.

§ 5-809. Record keeping; confidentiality; discovery

(a) Maintenance of records. -- The Committee shall maintain records of its deliberations including any recommendations.

(b) Records generally confidential; independent information. --

(1) Except for the public report issued under § 5-808(a) of this subtitle, any records of deliberations, findings, or files of the Committee shall be confidential and are not discoverable under § 1-401 of the Health Occupations Article.

(2) This subsection does not prohibit the discovery of material, records, documents, or other information that was not prepared by the Committee or its subcommittee and was obtained independently of the Committee or subcommittee.

(c) Testimony of involved persons; independent information. --

(1) Members of the Committee or a subcommittee of the Committee, persons attending a Committee or subcommittee meeting, and persons who present information to the Committee or subcommittee may not be questioned in any civil or criminal proceeding regarding information presented in or opinions formed as a result of a meeting.

(2) This subsection does not prohibit a person from testifying to information obtained independently of the Committee or subcommittee or that is public information.

(d) Prohibition on disclosure by involved persons. -

(1) Except as necessary to carry out the Committee's purpose and duties, members of the Committee or subcommittee and persons attending a Committee or subcommittee meeting may not disclose:

(i) What transpired at a meeting that is not public under this subtitle; or

(ii) Any information that is prohibited for disclosure by this section.

(2) This subsection does not prohibit the discovery of material, records, documents, or other information that was not prepared by the Committee or

its subcommittee and was obtained independently of the Committee or subcommittee.

HISTORY: 2000, ch. 470; 2002, ch. 19, § 9; 2006, ch. 268.

§ 5-810. Closed meetings

Meetings of the Committee and subcommittees shall be closed to the public and not subject to Title 10, Subtitle 5 of the State Government Article.

HISTORY: 2000, ch. 470; 2006, ch. 268.

ATTACHMENT 2

MQRC MEMBERSHIP

Committee Chair

- Keith Peterson, Chair, licensed provider of community developmental disability services

Committee Membership

- Joanna D. Brandt, MD, board certified psychiatrist
- Jason Noel, Pharm D., psychopharmacologist
- Mary G. Mussman, MD, licensed physician on staff with the Department
- Diane Coughlin, specialist in the field of developmental disabilities
- Donna Wells, specialist in the field of mental health
- Barrett Cisney, licensed provider of community mental health services
- Vicki Mills, developmental disability consumer
- Katie Rouse, mental health consumer
- Joyce Lipman, family member representing a consumer with a developmental disability
- Phyllis Zolotorow, family member representing a consumer with a mental illness
- VACANT, the Deputy Secretary of Behavioral Health and Disabilities designee
- Dr. Nay, Director of the Office of Health Care Quality designee
- Zabiullah Ali, MD, licensed physician representative from the Medical Examiner's Office
- LaVon Magruder, RN, licensed nurse who works with persons with developmental disabilities in a program operated by a State licensed provider in the community
- Carol Fried, a member of an advocacy group for persons with disabilities
- Dan Martin, member of a mental health advocacy group

- Vacant, member of a developmental disabilities group

Committee Counsel

Kathleen A. Ellis, Deputy Counsel, Assistant Attorney General, Office of the Attorney General-DHMH

Mortality Incident Review Committee

Lisa Hovermale, MD, licensed physician, MHA and DDA Liaison

Tricia Nay, MD, Licensed physician, OHCQ

Mary Crouse, RN, OHCQ

Bill Vaughn, RN, OHCQ